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7590 Alexander J. Burke Intellectual Property Department 5th Floor 170 Wood Avenue South Iselin, NJ 08830			EXAMINER RANGREJ, SHEETAL	
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**BEFORE THE BOARD OF PATENT APPEALS
AND INTERFERENCES**

Application Number: 10/608,254
Filing Date: June 27, 2003
Appellant(s): BALOGH, MARY

MAILED

DEC 13 2007

GROUP 3600

Elsa Keller
For Appellant

EXAMINER'S ANSWER

This is in response to the appeal brief filed October 2, 2007 appealing from the Office action mailed May 3, 2007.

(1) Real Party in Interest

A statement identifying by name the real party in interest is contained in the brief.

(2) Related Appeals and Interferences

The following are the related appeals, interferences, and judicial proceedings known to the examiner which may be related to, directly affect or be directly affected by or have a bearing on the Board's decision in the pending appeal:

U.S. Patent Application No. 10/608,254.

(3) Status of Claims

The statement of the status of claims contained in the brief is correct.

(4) Status of Amendments After Final

No amendment after final has been filed.

(5) Summary of Claimed Subject Matter

The summary of claimed subject matter contained in the brief is correct.

(6) Grounds of Rejection to be Reviewed on Appeal

The appellant's statement of the grounds of rejection to be reviewed on appeal is correct.

(7) Claims Appendix

The copy of the appealed claims contained in the Appendix to the brief is correct.

(8) Evidence Relied Upon

6341265	Provost et al.	01-2002
4491725	Pritchard	01-1985
5915241	Giannini, Jo Melinna	06-1999

5530861

Diamant et al.

06-1996

(9) Grounds of Rejection

The following ground(s) of rejection are applicable to the appealed claims:

Claim Rejections - 35 USC § 112

1. In regards to applicant's amendment, the examiner has withdrawn the 35 USC 112, second paragraph rejections made against claim 5.

2. The following is a quotation of the second paragraph of 35 U.S.C. 112:

The specification shall conclude with one or more claims particularly pointing out and distinctly claiming the subject matter which the applicant regards as his invention.

3. Claims 4 and 12 are rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention.

4. Claims 4 recites, "translating said interpreted received nonpayment code to said standard activity code." The examiner is unable to determine the difference between a nonpayment code and a standard activity code, because the specification defines the standard activity code referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an industry activity code, an open activity code, and the like (page 9, lines 31-33 and page 10, line 1). For examination purposes, the examiner will interpret the nonpayment code to be the same as a standard code.

The examiner requests that if the applicant has a different definition for nonpayment code, then the applicant should make a record of and show where in the specification it provides support for the definition.

5. Claim 12 recites, "said rejected claim data was accompanied by a denial or rejection notification." Applicant admits "the difference between denials and rejections is that the payer absolutely will not pay on the payment request for a denial, and that the payer may pay on the payment request for a rejection if the reason for the rejection is corrected" (Application, page 8, 14-19). Based on this admission, the examiner is unable to determine how the rejected claim data could be accompanied by a denial notification. For examination purposes, the examiner will interpret the claim data to be accompanied by denial or rejection notification.

Claim Rejections - 35 USC § 103

6. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

(a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negated by the manner in which the invention was made.

7. Claims 1-2, 12-14, and 16-17 are rejected under 35 U.S.C. 102(e) as being unpatentable by Provost et al. (U.S. Patent 6,341,265) in view of Pritchard (U.S. Patent 4,491,725).

8. As per claim 1, Provost teaches a method for processing claim data comprising the steps of:

a. Selecting an activity code from a predetermined activity code set identifying processing to be performed concerning claim data (Provost: column 6, lines 2-11). In light of the specification, the examiner interprets the "diagnosis code and the treatment code" to be the same as an activity code from a predetermined set of codes.

- b. Assigning said selected activity code (Provost: column 6, lines 4-5) to rejected (Provost: column 4, lines 24-27; column 13, lines 45-54) claim data.
- c. Scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one: amended rejected claim data (Provost: column 4, lines 27-35).
- d. Preparing said corrected claim data for submission to a payer organization (Provost: column 4, lines 35-38).

Provost does not explicitly teach including a standard activity code from a standard activity code set different to internal activity code set and facilitating compatible communication between a particular organization and a payer organization.

Applicant has amended claim 1, by adding the limitation preparing said corrected claim data by including a standard activity code from a standard activity code set different to internal activity code set and facilitating compatible communication between a particular organization and a payer organization. As per this element, it is evidenced by Pritchard (U.S. Patent No. 4,491,725) that CPT-IV code (i.e. standard activity card) is different from the four-digit service code (i.e. internal code), and also facilitates compatible communication through the data terminal (Pritchard: col. 8, 11-52).

Applicant has further amended claim 1, by adding the limitation to automatically provide an internal activity code to rejected claim data and scheduling a task to derive corrected claim data. As per this element, as evidenced by Prichard, it is well known in the claims processing art to, automatically or manually, assign diagnostic or procedural codes (i.e. claim data) to internal operational codes or nomenclature specific to an insurance company or hospital operation. The

examiner interprets that an appropriate error message, as in Pritchard, is the same as assigning a particular internal code to a rejected claim data. The examiner also interprets that the service provider correcting the form after the error message is sent is the same as a task being scheduled in response to assigned internal activity code. (Pritchard: col. 8, 4-52)

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time the invention was made to combine the teachings of Provost and Pritchard. One of ordinary skill would have been motivated to combine these teachings because routine processing of an insurance form can take many weeks and substantial time before the patient or medical service provider receives a reimbursement for the medical expense (Pritchard: col. 1, 21-25). It is further motivated to combine because insurance carriers develop fee payment schedules, which determine the fee that they will pay for each particular type of service. These tables are generally complex and involve hundreds of items dependent on several factors. (Pritchard: col. 1, 59-col. 2, 14). Hence, the automation reduces the rejections of claims.

9. As per claim 2, Provost teaches the method of claim 1 is as described above. Provost further teaches a set of codes identifying a nonpayment reason comprising at least one of: a rejection activity code and a denial activity code (Provost: column 10, lines 53-63).

Applicant has amended claim 2, by adding the limitation the predetermined internal activity code set is different from a set of code identifying nonpayment reason. As per this element, it is evidenced by Pritchard as discussed with regard to claim 1. The appropriate error message is the same as set of codes for a nonpayment reason and the conversion of CPT-IV code to four-digit service code for the selected insurance carries to be the same as the internal activity code.

10. As per claim 12, the method of claim 1 is as described above.

Provost further teaches determining from said notification whether said rejected claim data was denied or rejected (Provost: column 6, lines 12-15). In light of the specification, the examiner interprets “determination of the submitted claim will not be paid by an insurer” to be the same as a rejected claim data.

Provost further teaches selecting a first activity code (Provost: column 6, lines 2-7) in response to a denial notification and a different second activity code (column 6, lines 2-7) in response to a rejection notification (Provost: column 4, lines 7-16 and lines 52-55). In light of the specification, the examiner interprets “diagnosis code” to represent “first activity code” and “treatment code” to represent “second activity code.” In light of the specification, the examiner also interprets “feedback almost immediately to the medical technician specifying whether a submitted claim is in condition to be paid” to be the same as a notification for either a denial or a rejected claim.

Provost explicitly does not teach a first internal code to a denial notification and a second internal activity code to a rejection notification.

Applicant has amended claim 12, by adding the limitation a first internal code to a denial notification and a second internal activity code to a rejection notification. As per this element, it is evidenced by Pritchard that each CPT-IV code is converted to a service code for a particular insurance carrier. The examiner interprets that the codes that are denied by the insurance carrier, meaning the insurance carrier does not have a match for that code, will have first internal code and the codes that are rejected, meaning the insurance carrier does not pay for that service, will have a second internal code. (Pritchard: col. 8, 11-52)

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time the invention was made to combine the teachings of Provost and Pritchard with the same motivation as discussed for claim 1.

11. As per claim 13, the method of claim 1 is as described above.

Provost further teaches said method steps are performed automatically and at least one of excluding manual intervention (Provost: column 6, lines 47-62) by one or more healthcare workers.

12. As per claim 14, the method for processing claim data comprising the steps of:

- a. Identifying a nonpayment code, associated with a predetermined nonpayment code set (Provost: column 10, lines 57-63). In light of the specification, the examiner interprets the “informing that the treatment code is inconsistent” to be the same as identifying a nonpayment activity code.
- b. Selecting an activity code from a predetermined activity code set identifying processing to be performed concerning claim data (Provost: column 6, lines 2-11). In light of the specification, the examiner interprets the “diagnosis code and the treatment code” to be same as an activity code from a predetermined set of codes.
- c. Assigning said selected activity code (Provost: column 6, lines 4-5) to rejected (Provost: column 4, lines 24-27; column 13, lines 45-54) claim data.
- d. Scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one: amended rejected claim data (Provost: column 4, lines 27-35).

- e. Preparing said corrected claim data for submission to a payer organization
(Provost: column 4, lines 35-38).

Applicant has amended claim 14, providing the same limitations as claim 1. Please see discussion for claim 1 above.

13. As per claim 16, the method of claim 14 is as described above. Provost further teaches predetermined nonpayment code set compatible with a HIPAA standard code set (Provost: column 6, lines 2-6). According to HIPAA law, the term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

14. As per claim 17, Provost teaches a system for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising:

- a. A workflow processor for,

- (1) Selecting an activity code from a predetermined activity code set including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection (Provost: column 6, lines 2-11);
- (2) Assigning said selected activity code (Provost: column 6, lines 4-5) to rejected claim data (Provost: column 4, lines 24-27; column 13, lines 45-54) associated with said received notification;
- (3) Scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least

one (b) amended rejected claim data (Provost: column 4, lines 27-35), in response to said assigned selected activity code; and

(4) An interface processor for preparing said corrected claim data for submission to a payer organization for payment (Provost: column 7, lines 20-27).

Applicant has amended claim 17, providing the same limitations as claim 1. Please see discussion for claim 1 above.

15. Claims 3-5 and 15 are rejected under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent 6,341,265) in view of Giannini (U.S. Patent 5,915,241), and further in view of Pritchard (U.S. Patent 4,491,725).

16. As per claim 3, the method of claim 1 is as described. The Provost patent further teaches receiving a nonpayment code comprising at least one of: a rejection code and a denial code (Provost: column 10, lines 57-63). The specification defines the standard activity code for the rejection or denial communications is otherwise referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an industry activity code, an open activity code, and the like (page 9, lines 31-33 and page 10, line 1). In light of the specification, the examiner interprets the “informing that the treatment code is inconsistent” to be the same as receiving a nonpayment activity code.

Provost does not teach said selecting step comprises interpreting said received nonpayment code to determine from said predetermined activity code set, an activity code compatible with said nonpayment code.

Giannini teaches said selecting step comprises interpreting said received nonpayment code to determine from said predetermined activity code set, an activity code compatible with said nonpayment code (Giannini: column 9, lines 61-67 and column 10, lines 1-6). In light of the specification, the examiner interprets the Alternative Billing Code to be the same as nonpayment code.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Gianni with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that "as alternative medicine is brought into mainstream medicine, alternative providers have attempted to use these codes, but their claims are not understood by the payers because accurate descriptions of the services they perform do not exist therein. Furthermore, ICD-9-CM and CPT codes do not identify the practitioner by profession. For these reasons, "dummy billing codes" or codes designed by individual payers to cope with payment for alternative treatments have been developed by a few carriers which offer payment benefits to alternative medicine" (Giannini: column 1, lines 63-67 and column 2, lines 1-6).

Applicant has amended claim 3, providing the same limitations as claim 1. Please see discussion for claim 1 above.

17. As per claim 4, the method of claim 1 is as described. The Provost patent further teaches receiving a nonpayment code comprising at least one of: a rejection code (Provost: column 10, lines 57-63). The specification defines the standard activity code for the rejection or denial communications is otherwise referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an industry activity code, an open activity code, and the like

(page 9, lines 31-33 and page 10, line 1). In light of the specification, the examiner interprets the "informing that the treatment code is inconsistent" to be the same as receiving a rejected nonpayment activity code.

Provost does not teach interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with said nonpayment code set employed by an organization.

Giannini teaches interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with a predetermined nonpayment code set employed by an organization (Giannini: column 9, lines 61-67 and column 10, lines 1-6). In light of the specification, the examiner interprets the Alternative Billing Code to be nonpayment code.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Gianni with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that as alternative medicine is brought into mainstream medicine, alternative providers have attempted to use these codes; but their claims are not understood by the payers because accurate descriptions of the services they perform do not exist therein. Furthermore, ICD-9-CM and CPT codes do not identify the practitioner by profession. For these reasons, "dummy billing codes" or codes designed by individual payers to cope with payment for alternative treatments have been developed by a few carriers which offer payment benefits to alternative medicine (Giannini: column 1, lines 63-67 and column 2, lines 1-6).

18. As per claim 5, the method of claim 4 is as described above.

The Provost patent does not teach predetermined nonpayment code set includes fewer codes than a code set used to derive said received nonpayment code.

The Giannini patent teaches predetermined nonpayment code set (Giannini: column 1, lines 53-62) includes fewer codes (Giannini: column 2, lines 13-16) than a code set used to derive said received nonpayment code (Giannini: column 2 lines 1-8). In light of the specification, the examiner interprets “CPT codes”, “codes by individual payers”, and “description codes” to be the same as a nonpayment code. The examiner also interprets “description codes are not comprehensive and fail to account for all services” to be the same as the predetermined description code set (nonpayment code) to be fewer than the received service codes.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Giannini with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that in cases where certain specialties perform procedures which cross many sub-specialties, the procedures fall into more than one of the numerated rubrics of CPT codes and the burden on the practitioner to learn the proper classification becomes particularly undue (Giannini: column 3, lines 14-20).

Provost and Giannini do not explicitly teach translating nonpayment code to an internal activity code.

Applicant has amended claim 5, by adding the limitation translating nonpayment code to an internal activity code. As per this element, it is evidenced by Pritchard that CPT-IV (i.e. nonpayment code) is translated into a four-digit service code (i.e. internal activity code) for the

selected insurance carrier. CPT-IV is a nonpayment code due to the fact that the service was provided to the patient, yet has not been paid because it first needs to be translated by the insurance carrier to determine how much the patient owes.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time the invention was made to combine the teachings of Provost in view of Giannini with Pritchard. One of ordinary skill would have been motivated to combine these teachings because routine processing of an insurance form can take many weeks and substantial time before the patient or medical service provider receives a reimbursement for the medical expense (Pritchard: col. 1, 21-25). It is further motivated to combine because insurance carriers develop fee payment schedules, which determine the fee that they will pay for each particular type of service. These tables are generally complex and involve hundreds of items dependent on several factors. (Pritchard: col. 1, 59-col. 2, 14). Hence, the automation reduces the rejections of claims.

19. As per claim 15, the method of claim 14 is as described above.

Provost further teaches receiving a nonpayment code comprising at least one of: a rejection code and a denial code (Provost: column 10, lines 57-63). The specification defines the standard activity code for the rejection or denial communications is otherwise referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an industry activity code, an open activity code, and the like (page 9, lines 31-33 and page 10, line 1). In light of the specification, the examiner interprets the “informing that the treatment code is inconsistent” to be the same as receiving a nonpayment activity code.

Provost does not teach interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with said nonpayment code set employed by an organization.

Giannini teaches interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with a predetermined nonpayment code set employed by an organization (Giannini: column 9, lines 61-67 and column 10, lines 1-6). In light of the specification, the examiner interprets the Alternative Billing Code to be nonpayment code.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Gianni with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that as alternative medicine is brought into mainstream medicine, alternative providers have attempted to use these codes; but their claims are not understood by the payers because accurate descriptions of the services they perform do not exist therein. Furthermore, ICD-9-CM and CPT codes do not identify the practitioner by profession. For these reasons, "dummy billing codes" or codes designed by individual payers to cope with payment for alternative treatments have been developed by a few carriers which offer payment benefits to alternative medicine (Giannini: column 1, lines 63-67 and column 2, lines 1-6).

Applicant has amended claim 15, providing the same limitations as claim 1. Please see discussion for claim 1 above.

20. Claims 6-11 are rejected under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent 6,341,265) in view of Diamant et al. (U.S. Patent 5,530,861) and further in view of Pritchard (U.S. Patent 4,491,725).

21. As per claim 6, the method of claim 1 is as described above.

Provost does not teach assigning a time and date identifier to rejected claim data indicating a time and date indicative of *at least one* of (a) a time and date associated with scheduling a task comprising performing processing concerning said rejected claim data, (b) a time and date associated with processing said received notification of claim denial or rejection, (c) a time and date associated with receiving notification of claim denial or rejection, and (d) a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data.

Diamant teaches assigning a time and date identifier to rejected claim data indicating a time and date indicative of *at least one* of (d) a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data (Diamant: column 6, lines 18-24).

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because “current tools are limited in that they do not define hooks to the actual work performed or to project management tools. For example, they cannot automatically track time spent executing tasks (Diamant: column 1, lines 28-33).”

22. As per claim 7, the method of claim 1 is as described above.

Provost does not teach assigning a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data and initiating generation of a message alerting a user at least one of said period is due to expire at said time and date or said period has expired.

Diamant teaches assigning a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data (Diamant: column 6, lines 18-20) and initiating generation of a message alerting a user at least one of said period is due to expire at said time and date (Diamant: column 6, lines 20-24) or said period has expired.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because “current tools are limited in that they do not define hooks to the actual work performed or to project management tools. For example, they cannot automatically track time spent executing tasks. Additionally, tools are limited because they do not include triggers for automatically initiating actions in the computing environment based on the task (Diamant: column 1, lines 28-38).”

23. As per claim 8, the method of claim 1 is as described above.

Provost does not teach collating data by at least one of payer organization or reason for claim rejection or denial.

Diamant teaches collating data by at least one of payer organization (Diamant: column 15, lines 13-21). In light of the specification, the examiner interprets “selection of a filter and applying the filter” to be the same as “collating data by payer organization.”

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Provost discloses that “delivery of health care services has shifted from individual physicians to large managed health maintenance organizations. This shift reflects the growing number of medical, dental, and pharmaceutical specialists in a complex variety of health care options and programs. This complexity and specialization has created large administrative systems that coordinate health care providers, administrators, patients, payers, and insurers (Provost: column 1, lines 14-30).

24. As per claim 9, the method of claim 1 is as described above.

Provost does not teach collating rejected claim data by at least one of payer organization, assigned activity code, or type of request for information indicated in a corresponding notification.

Diamant teaches collating rejected claim data by at least one of payer organization (Diamant: column 15, lines 13-21). In light of the specification, the examiner interprets “rejected claim data” to be attached with a task that needs to be performed to resubmit the claim; therefore, the filter, payer organization, is applied to the tasks.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Provost discloses that “delivery of health care services has shifted from individual physicians to large managed health maintenance organizations. This shift reflects the growing number of

medical, dental, and pharmaceutical specialists in a complex variety of health care options and programs. This complexity and specialization has created large administrative systems that coordinate health care providers, administrators, patients, payers, and insurers (Provost: column 1, lines 14-30).”

25. As per claim 10, the method of claim 1 is as described above.

Provost does not teach acquiring statistics concerning at least one of, (a) type and frequency of claim rejections, (b) type and frequency of claim denials, (c) data identifying success rate of first time claims submissions for an individual payer, (d) data indicating a time duration expected for processing of a submitted claim for an individual payer, (e) data indicating a time duration expected for processing a non-paid claim until re-submission and (f) data identifying a proportion of non-recoverable claims for an individual payer.

Diamant teaches acquiring statistics concerning at least one of, (d) data indicating a time duration expected for processing of a submitted claim for an individual payer (Diamant: column 6, lines 13-17).

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because “many claims are subject to multiple submission and adjudication cycles, as they are successively created, rejected, and amended. Each cycle may take several weeks or more, and the resulting duplication of effort decreases the efficiency of the health care system” (Provost: column 2, lines 42-49) and therefore acquiring the statistics will help understand the amount of time it takes to successfully submit a claim.

26. As per claim 11, the method of claim 10 is as described above.

Provost does not teach employing said statistics to at least one of modify processing of said rejecting claim data or create a statistical report for an individual payer.

Diamant teaches employing said statistics to at least one of modify processing of said rejecting claim data or create a statistical report for an individual payer (Diamant: column 6, lines 13-17). In light of specification, the examiner interprets “tasktimelog file” to be the same as a “statistical report.”

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because “many claims are subject to multiple submission and adjudication cycles, as they are successively created, rejected, and amended. Each cycle may take several weeks or more, and the resulting duplication of effort decreases the efficiency of the health care system” (Provost: column 2, lines 42-49) and therefore employing the statistics will help understand the amount of time it takes to successfully submit a claim.

(10) Response to Argument

In the appeal brief filed October 2, 2007, Appellant makes the following arguments:

(A) Although the definition of a standard activity code does encompass nonpayment activity code, and may represent a nonpayment code, a standard activity code is not the same as “a nonpayment code” as recited in claim 4 of the present invention. A nonpayment code is not the same as a nonpayment activity code because the nonpayment code is interpreted and translated.

The examiner disagrees and reasserts that the applicant agrees that “the definition of a standard activity code does encompass nonpayment activity code, and may represent a nonpayment code”

(B) Applicant states that there is no inconsistency in claim 12 and Applicant does not understand the rejection with respect to claim 12, which states that “the examiner is unable to determine how the rejected claim data could be accompanied by a denial notification.” The applicant states that the difference between a denial and a rejected claim data is that a rejected claim data is that the insurance carrier is not paying the submitted claim at all and a denial claim data is that the claim submitted has errors and is not in the proper form for submission. Based on that definition, Examiner is unable to interpret that if a rejected claim data is being notified, then how can that notification data also be a denial notification.

(C) Provost neither discloses nor suggests the use of an “internal activity code” to automatically schedule internal workflow processing, including automatic task scheduling, for use in preparing “corrected claim data.”

Applicant argues that the codes used by Provost are not automatically selected. Examiner argues that providing an automatic means to replace a manual activity that accomplishes the same result is not sufficient to distinguish over the prior art (*In re Venner* MPEP 2144.04 R-1 (III)).

Furthermore, Applicant states that after the diagnosis and treatment codes are manually entered, they are communicated and checked by a remote system to determine if the claim is in condition to be paid. Applicant argues that this is wholly unlike the claimed arrangement which “automatically selects an internal activity code...in response to a received notification of claim denial or rejection.” Examiner argues that Provost discloses that when a submitted claim is not

to be paid by an insurer, a notification is transmitted to the technician, who amends the codes to place the claim in condition to be paid (Provost: col. 6, 2-22), Therefore discloses that a selection of an internal activity code is performed in response to a received notification of claim denial or rejection.

(D) Provost neither discloses nor suggests using a “standard activity code” that is different from the “internal activity code” to facilitate “compatible communication between” a payer organization and a payee organization.

Applicant argues that the codes used in Provost are descriptive codes that provide identification of a diagnosis and treatment for a diagnosis, which is unlike the "internal activity code" and the "standard activity code" used in the present claimed invention. Examiner states that in the Office Action filed May 3, 2007, Examiner states that Provost does not explicitly teach standard activity code from a standard activity code set is different to internal activity code set, but the limitations are supported by Pritchard.

(E) Provost provides no 35 USC 112 compliant enabling disclosure of the activity of “automatically assigning said selected internal activity code to rejected claim data associated with said received notification.” Transmitting data indicating why a claim is not in condition to be paid does not suggest “automatically assigning said selected internal activity code to rejected claim data associated with said received notification.”

The Examiner disagrees and states that Provost provides 35 USC 112 compliant enabling disclosure of the activity of “automatically assigning said selected internal activity code to rejected claim data associated with said received notification.”

(F) Provost fails to provide enabling disclosure of the step of “automatically scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data.” The Examiner disagrees and states that Provost provides 35 USC 112 compliant enabling disclosure of the activity of “automatically scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data.” The cited section of Provost further defines the information transmitted by the remote system to the client upon determining that a claim is not in proper form for payment. There is no mention of “scheduling a task” for any purpose. Examiner disagrees and states that Provost discloses where the medical technician is prompted to amend the claim form to provide a corrected claim data, therefore scheduling a task to be performed to derive corrected claim data.

(G) Provost fails to provide 35 USC 112 compliant enabling disclosure or suggest “preparing said corrected claim data by including a standard activity code...different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment.” The Examiner states that the activity of “preparing said corrected claim data by including a standard activity code...different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment” is performed by Pritchard.

(H) Applicant argues that although the cited passage of Pritchard described a “CPT-IV code, which was entered by the service provider onto a standard form...converted by use of Table 72 for the appropriate insurance carrier, herein labeled XYZ Mutual” (col. 8, 12-16), where “the five digit CPT-IV code [is converted] into a four digit service code for the selected insurance

carrier" (col. 8, 16-18), the codes are unlike the present claimed invention. Applicant argues that Pritchard may describe converting the CPT-IV code to a four digit code, however, the service code identifies a medical service already performed for a patient and not an activity to be performed in processing a claim denial/rejection, as in the claimed invention.

Examiner disagrees and states that Pritchard discloses that after the CPT-IV code is converted to a service code, that service code is referenced as a file for a particular carrier. That service code is utilized to read payment information for that particular service code for that insurance carrier (col. 8, 16-25), therefore Pritchard discloses "preparing said corrected claim data by including a standard activity code...different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment."

(I) Applicant argues that unlike the present claimed invention which processes denial claim data after billing and rejection/denial, the combined system of Provost and Pritchard occurs prior to billing. The Examiner disagrees and states that the claimed invention selects an activity code, assigns the activity code to claim data, schedules a task processing claim data to derive corrected claim data, and preparing the corrected claim data for submission; the step of processing denial claim data AFTER billing and rejection/denial is not found in the claimed invention; therefore the combined system of Provost and Pritchard disclose the claimed invention.

(J) Applicant states that the Rejection argues that "an appropriate error message, as in Pritchard, is the same as assigning a particular internal code to a rejected claim data. The Examiner also interprets that the service provider correcting the form after an error message is the same as a task being scheduled in response to assigned internal activity code." Applicant

argues that the error message in Pritchard “is sent from a computer via a link to the local terminal” upon an error being detected in a form. Therefore, the error message in Pritchard is created in response to a form being incorrectly prepared and not “meeting the requirements of the patient’s insurance carrier.”

Examiner argues that Pritchard (col. 8, 4-10) does provide the support for “automatically assigning said selected internal activity code to rejected claim data associated with said received notification.” Pritchard discloses an error message (i.e. received notification) in response to a rejected claim data (i.e. not ready for payment). Pritchard also teaches assigning internal activity code to claim data (col. 8, 11-25).

(K) The codes in Pritchard are patient treatment codes that are converted to insurance carrier service codes, which is unlike the claimed invention in which the “predetermined internal activity code set is different from the set of codes identifying a nonpayment reason associated with the rejected claim data.” Provost does not explicitly teach “predetermined internal activity code set is different from the set of codes identifying a nonpayment reason associated with the rejected claim data,” but teaches the nonpayment reason associated with the rejected claim and in combination with Pritchard, which teaches “predetermined internal activity code set is different from the set of codes.” Therefore, one of ordinary skill in the art at the time the invention was made would have found it obvious to combine the teachings.

(L) Applicant argues that Provost in view of Pritchard neither discloses nor suggests claim

12. Applicant argues that Provost does not distinguish between a rejection and a denial, however, Examiner states the Provost discloses where if the server determines that the submitted claim will not be paid, the technician is informed of this result; who in response could amend the

claim data for payment or have the claim data be rejected if the patient is not a beneficiary of the approved insurance plan (Provost: col. 7, 41-51).

(M) Applicant argues that Provost in combination with Pritchard does not teach "selecting a first internal code and a second internal code." Examiner disagrees and states that Pritchard teaches "selecting a first internal code and a second internal code" (col. 8, 11-52). Examiner states that Pritchard discloses where each CPT-IV code is converted to an internal code of a particular insurance carrier; and according to that insurance carrier for a particular patient, a claim given a service code (i.e. converted CPT-IV code) could be rejected or denied based on the plan for that patient; therefore, Pritchard calculates the amount to be paid by an insurance carrier (col. 8, 30-43).

(N) Applicant argues that Provost fails to teach "automatically assigning a task to a list of a worker comprising performing processing concerning said particular claim data to derive corrected claim data." Examiner disagrees, and states that Provost discloses informing the medical technician (i.e. assigning a task) to prepare the claim data to derive corrected claim data.

(O) Applicant argues that since the Provost and Pritchard system will not accept a claim that will not be paid due to the comparison by the remote system, Provost and Pritchard would not be able to process and allow a claim having a code identifying non-conventional medical treatment that is not typically covered by the insurance plan of the patient. Thus, the Provost and Pritchard system and the Giannini system each accomplish distinct and unrelated objectives. Examiner disagrees, and argues that the Giannini system discloses interpreting said received nonpayment code to determine an activity code compatible with said nonpayment code, interpreting the received non payment code and translating to a code compatible with a predetermined

nonpayment code employed by an organization, and nonpayment code set to have fewer codes than a code set used to derive the nonpayment code. Giannini system is used for disclosing the claimed invention's "internal code set" conversion, therefore, it teaches in combination with Provost in view of Pritchard, the claimed invention.

(P) Applicant argues that Giannini provides a system for creating a claim and calculating payment amount for the claim based on a formula. Additionally, Giannini is not concerned with "interpreting said identified nonpayment code to determine from said predetermined internal activity code set, an internal activity code compatible with said nonpayment code." The code employed by Giannini is not the cost amount of a non-conventional medical procedure, but an alternative code for the service provided by the providers (CPT codes).

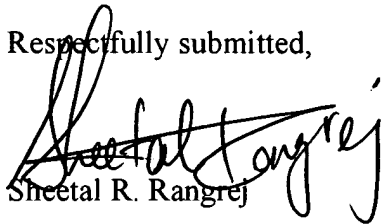
(Q) Applicant argues that Diamant is a nonanalogous art and one skilled in the art would not seek to combine an insurance claim pre-processing system as taught by Provost in view of Pritchard with an automatic task management system as taught by Diamant. Examiner disagrees and argues that Diamant provides a task management tool, which is analogous to a healthcare service art, where hospital management, with submission of claims for patients, require a task management tool.

(11) Related Proceeding(s) Appendix


No decision rendered by a court or the Board is identified by the examiner in the Related Appeals and Interferences section of this examiner's answer.

For the above reasons, it is believed that the rejections should be sustained.

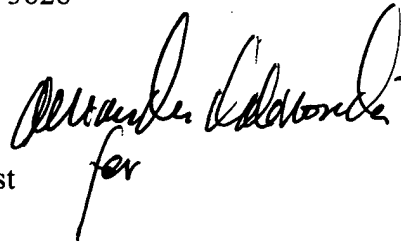
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